Medicare

HOSPICE BENEFITS

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A Special Way of Caring for the Terminally Ill

U.S. Department of Health and Human Services
Health Care Financing Administration

Hospice benefits under Medicare

Hospice care is a special way of caring for a patient whose disease cannot be cured. It is available as a benefit under Medicare Hospital Insurance (Part A). Medicare beneficiaries who choose hospice care receive non-curative medical and support services for their terminal illness. To be eligible, they must, among other things, be certified by a physician to be terminally ill with a life expectancy of approximately six months or less. While they no longer receive treatment toward a cure, they require close medical and supportive care which a hospice can provide. Hospice care under Medicare includes both home care and inpatient care, when needed, and a variety of services not otherwise covered by Medicare. The focus is on care, not cure. Emphasis is on helping the person to make the most of each hour and each day of remaining life by providing comfort and relief from pain.

This leaflet explains the special rules that govern Medicare's coverage of, and payment for, hospice care.

What is hospice care?

Under Medicare, hospice is primarily a program of care delivered in a person's home by a Medicare-approved hospice. Reasonable and necessary medical and support services for the management of a terminal illness are furnished under a plan-of-care established by the hospice and the beneficiary's attending physician. Medicare covers:

- physicians' services,
- nursing care,
- medical appliances and supplies,
- outpatient drugs for symptom management and pain relief,
- short-term inpatient care, including respite care,

- home health aide and homemaker services,
- physical therapy, occupational therapy and speech/language pathology services,
- medical social services, and
- counseling, including dietary counseling.

When a patient receives these services from a Medicare-approved hospice, Medicare Hospital Insurance pays almost the entire cost. The only expense to the beneficiary is limited cost-sharing for outpatient drugs and biologicals and inpatient respite care (see page 4).

Who is eligible?

Hospice care is available only if:

- The patient is eligible for Medicare Hospital Insurance (Part A);
- The patient's doctor and the hospice medical director certify that the patient is terminally ill;
- The patient signs a statement choosing hospice care instead of standard Medicare benefits for the terminal illness;
- A written plan-of-care is established for the patient and regularly reviewed; and
- The patient receives care from a Medicare-approved hospice program.

Who can provide hospice care?

Hospice care can be provided by a public agency or organization that is primarily engaged in furnishing services to terminally ill individuals and their families. To receive Medicare payment, the agency or organization must be approved by Medicare to provide hospice services.

Approval is required even if the agency or organization is already approved by Medicare to provide other kinds of health services. Patients can find out whether a hospice program is approved by Medicare by asking their physician or checking with the agency or organization offering the program. This information also is available from local Social Security offices.

Hospice uses a team approach that includes family, nurses, social workers, physicians, clergy and volunteers, all working together to plan and coordinate care. Family or friends providing care in the home can call for the help of a hospice team member 24 hours a day, 7 days a week. The team member will come to the patient's home whenever needed and appropriate. The hospice team can arrange for a transfer to another setting when necessary.

How long can hospice care continue?

Special benefit periods apply to hospice care. A Medicare beneficiary may elect to receive hospice care for two 90-day benefit periods, followed by a 30-day period, and when necessary, an extension period of indefinite duration. The benefit periods may be used consecutively or at intervals. Regardless of whether they are used one right after the other or at different times, the patient must be certified as terminally ill at the beginning of each period.

A patient who chooses hospice care may change hospice programs once each benefit period. A patient also has the right to cancel hospice care at any time and return to standard Medicare coverage, then later re-elect the hospice benefit if another benefit period is available. If a patient cancels during one of the first three benefit periods, any days left in that period are lost, but the patient is still eligible for the remaining benefit period(s). For example, if a patient cancels at the end of 60 days in the first 90-day period, the remaining 30 days in the period are forfeited. The patient is, however, still eligible for the second 90-day period, the 30-day

period, and the indefinite extension. If cancellation occurs during the final period, the patient returns to standard Medicare coverage and cannot use the hospice benefit again.

How is payment made?

Medicare pays the hospice directly at specified rates depending on the type of care given each day. The patient is responsible only for:

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- Drugs or biologicals: The hospice can charge 5 percent of the reasonable cost, up to a maximum of $5, for each prescription for outpatient drugs or biologicals for pain relief and symptom management.

- Inpatient Respite care: The hospice may periodically arrange for inpatient care for the patient to give temporary relief to the person who regularly provides care in the home. Respite care is limited each time to a stay of no more then 5 days. The patient can be charged about $4.48 per day for inpatient respite care. The charge, which is subject to change each year, varies slightly depending on the geographic area of the country.

Are other Medicare benefits available?

When Medicare beneficiaries choose hospice care, they give up the right to standard Medicare benefits for treatment of the terminal illness. Medicare pays the entire cost of the covered services required to manage the illness, except the copayments for respite care and outpatient prescription drugs and biologicals. A hospice patient can, however, qualify for standard Medicare benefits if:

- The patient has Medicare Supplementary Medical Insurance (Part B) and the patient's attending physician is not working for the hospice. In that case, Medicare Part B will help pay for the physician's services.

Medicare pays 80 percent of the approved amount for covered services after the patient meets the Part B annual deductible ($100 in 1993).

- The patient requires covered Medicare services for the treatment of a condition unrelated to the terminal illness.

What is not covered?

All services required for treatment of the terminal illness must be provided by or through the hospice. When a Medicare beneficiary chooses hospice care, Medicare will not pay for:

- Treatment for the terminal illness which is not for symptom management and pain control;
- Care provided by another hospice that was not arranged for by the patient's hospice; and
- Care from another provider which duplicates care the hospice is required to provide.

For further information

To determine whether Medicare-approved hospice is available in your area contact the nearest Social Security Administration office, your state or local health department or your state hospice organization. For more detailed information about the Medicare program, please refer to *The Medicare Handbook*. Free copies are available by calling 1-800-638-6833. Information about hospice care is also available from The National Hospice Organization, 1901 North Moore Street, Suite 901, Arlington, VA 22209. The organization's telephone number is 1-800-658-8898.

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